



PHYSICAL THERAPY BOARD OF CALIFORNIA

Consumer Protection Services Program

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CONSUMER COMPLAINT FORM

PERSON REGISTERING THE COMPLAINT

Please Print or Type

Mr. <input type="checkbox"/> Ms. <input type="checkbox"/>		
Name:	_____	
	(Last Name)	(First Name) (M.I.)
Mailing Address:	_____	
	(City)	(State) (Zip)
Phone Number:	_____	
	(Daytime Number)	(Evening Number) (Cell phone/E-mail address)
Mr. <input type="checkbox"/> Ms. <input type="checkbox"/>		
Patient Name:	_____	
	(Last Name)	(First Name) (M.I.)
Patient Date of Birth:	_____	Your Relationship to Patient: _____

I wish to complain about the individual named below. I understand that the Physical Therapy Board of California cannot seek restitution for damages, not provide legal advice or assist with lawsuits. I am, however, submitting this information so that it may be determined whether disciplinary action against the practitioner's license should be considered.

Check One:	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Physical Therapist Assistant	<input type="checkbox"/> Physical Therapy Aide	<input type="checkbox"/> Other
COMPLAINT REGISTERED AGAINST				
Name:	_____			
	(Last Name)	(First Name)	(M.I.)	
License No. (If known):	_____	Office/Facility Name	_____	
Street Address:	_____			
	(Address)	(City)	(State)	(Zip Code)
Phone Number:	_____			
Has the patient been examined/treated by another professional for this same condition?				
<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, provide name and address on Authorization for Release of Medical Information				
Reason for Treatment:	_____			
Date(s) of Treatment:	_____			

